

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN2602	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/14/2010
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER - MOUNTAIN VIEW			STREET ADDRESS, CITY, STATE, ZIP CODE 1360 BYPASS ROAD WINCHESTER, TN 37398		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments An annual Licensure survey and investigation of complaint #25400 were completed on April 14, 2010, at Golden Living Center - Mountain View. No deficiencies were cited under 1200-8-6, Standards for Nursing Homes. No deficiencies cited for complaint #25400.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

TITLE

Executive Director

(X6) DATE

4/28/10

6899

8LEV11

If continuation sheet 1 of 1

APR 29 2010